REPORT OF THE HOUSE INTERIM COMMITTEE ON QUALITY NURSING SERVICES AND PATIENT CARE

December 30, 1999

December 30, 1999

The Honorable Steve Gaw
Speaker of the House
State Capitol
Jefferson City, MO 65101

Dear Mr. Speaker:

The House Interim Committee on Quality Nursing Services and Patient Care you appointed has met, taken testimony, deliberated, and developed recommendations for improving nursing services and patient care. The undersigned members of the Committee are pleased to submit the attached report.

Representative Joan Barry, Chair

Representative Linda Bartelsmeyer

Representative Chuck Graham

Representative Harry Kennedy

Representative Patrick Naeger

Representative Bill Tudor

Representative Wes Wagner

TABLE OF CONTENTS

I. INTRODUCTION

Recent changes in the delivery of health care, most notably the restructuring of medical insurance through systems of managed care, have resulted in organizational changes for hospitals and other acute care medical settings. Concerns about how these changes have affected the quality of nursing services and patient care have been expressed by many health care professionals and patients. Legislation was introduced in 1999 to provide protections for those health care professionals who disclose information related to substantial health care dangers or deficiencies, to allow these professionals to speak freely without fear of reprisal, the so-called "whistleblower" protection legislation. Although this legislation was not passed, its introduction opened up dialogue among the interested parties and those with concerns about the quality of nursing services and patient care found in many health care facilities. To further the dialogue and to provide for a thorough examination of these issues, the Speaker of the House established the House Interim Committee on Quality Nursing Services and Patient Care, and appointed the following members: Representative Joan Barry (Chair), Representative Linda Bartelsmeyer, Representative Chuck Graham, Representative Harry Kennedy, Representative Patrick Naeger, Representative Bill Tudor, and Representative Wes Wagner. The interim committee solicited public testimony during four public hearings:

November 11, 1999	St. Louis
December 7, 1999	Kansas City
December 8, 1999	Springfield
December 10, 1999	Jefferson City

The Jefferson City hearing on December 10, 1999 also served as a work session for committee members, during which the issues raised by public testimony and committee recommendations were discussed.

II. PUBLIC TESTIMONY

Public testimony centered around the changes in the delivery of health care which affect how patients are cared for, and largely pertained to health care in hospitals. The testimony can be grouped into one of the following four categories:

A. Insufficient Numbers of Licensed Nurses

Numerous witnesses reported that changes in the administration of hospitals result in either a decreased number of nurses or the replacement of licensed registered nurses with non-licensed personnel (e.g., nursing technicians) or non-nursing staff (e.g., paramedics). A number of registered nurses reported that in the hospitals in which they work, organizational "downsizing" and related cost containment measures have caused the number of nurses employed in hospital facilities to remain static or in many cases to decline, so that fewer registered nurses are available to handle the nursing work load than was the case in years past. The Department of Health provided data on the number of registered nurses (RN's) in the state and the number of RN's who are employed in hospital settings[1]:

	1995	1999
Total Number of RN's	30,435	48,707
Number Employed in Hospitals	30,435	27,169

These data suggest that while the number of nurses in the state has increased, the number of nurses employed in hospital settings has declined between 1995 and 1999. This trend is supported by the testimony of several witnesses, who report that while there may not be a nursing shortage per se, there is a nursing shortage in hospitals. These data and testimony are not supported by the Missouri Hospital Association, which reports that comparisons of hospital nurse staffing per 1,000 residents in the state's metropolitan areas for 1996, 1998, and 1999 do not show a significant or consistent pattern of change. However, it appears that more and more registered nurses are opting, for a variety of reasons, to move out of hospital employment and in to administrative positions or other non-nursing positions. Foremost among the reasons cited for this employment shift is the experience of being "overworked and overstressed", which contributes to a feeling of being unable to provide the best care possible to one's patients. A number of registered nurses described the long shifts required in hospital settings, with shifts of 12, 14 and sometimes 15 hours increasingly common. Mandatory overtime or "hold-over time" was also described as a common feature of hospital employment, affecting not only the ability of nurses to provide quality care but also negatively impacting their personal lives. Registered nurses report they are required to do more and more work with fewer and fewer staff, or are moved from unit to unit within hospitals without regard to the nurses' areas of specialization, training or interests. In sum , there does not appear to be a nursing shortage but, as one physician who testified described it, a "shortage of nurses willing to do nursing in hospitals".

Related to the apparent decreased number of registered nurses working in hospitals is the trend reported by a number of witnesses to replace licensed nurses, in particular registered nurses, with

either unlicensed staff, such as nursing technicians or certified nursing assistants, or with licensed staff who are not nurses, such as paramedics. Several witnesses attributed this staffing pattern to the "corporatization" of hospitals, with financial concerns pushing hospital administrations to replace registered nurses with part-time personnel or with less costly unlicensed staff. These staff typically do not have the training required of nurses. Several witnesses reported that some hospitals assign non-nursing staff to perform functions previously assigned to registered nurses, with the non-nursing staff receiving minimal, on-the-job training in medical procedures/ services. Using relatively untrained staff to provide patient care can obviously adversely affect the quality of patient care. An example relayed to the committee involves blood pressure readings. Although it takes little training to learn how to take vital signs, such as a blood pressure reading, being able to interpret these levels in light of a patient's illness does require knowledge usually not possessed by those without extensive training. Another witness who is a retired RN described her recent stay in a hospital during which she observed "poorly educated" and relatively untrained persons providing medical care to critically ill patients; she described the attempt by one such staff member to change the dressing on an incision without using a sterile technique. Still another witness discussed the use of paramedics in a hospital lab/surgery unit, who were allowed to perform medical tasks even Licensed Practical Nurses (LPN's) are not allowed to perform.

Considerable testimony was provided to the Committee about the consequences of insufficient numbers of licensed nurses on hospital staffs. While such understaffing can and does have an adverse affect on the nursing staffs (e.g., stress levels increase, mandatory overtime depletes leisure and family time, chemical dependency is observed among some nurses), most of the

testimony on understaffing consequences relates to the affect on patients. Licensed nurse understaffing can result in an outbreak of infectious conditions among patients, as staff who are overworked, undertrained, or both, may not always follow sanitary procedures or employ sterile techniques. It was also reported to the Committee that insufficient numbers of licensed nurses sometimes results in delays in the administration of patient medications, with the potential to seriously retard recovery or negatively impact patients' conditions. One witness reported a lengthy delay in receiving the pain medication ordered by his physician before nurses in one hospital had the time to administer his medication. A 1998 study examining post-operative conditions and nurse staffing levels published by the Agency for Health Care Policy and Research[2] found a significant and inverse relationship between nurse staffing levels and the occurrence of such post-operative conditions as thrombosis, urinary tract infections, pneumonia, and pulmonary problems. Over 580 hospitals in various regions of the U.S. were included in the study sample. In another study conducted by the Minnesota Nurses Association using survey and interview data[3], nurses who reported shortages in nurse staffing levels expressed concerns with compromises in patient care, and a lack of supportive working environments for nurses which affects the quality of patient care (pp. 6-7). In summary, insufficient numbers of licensed nurses, in particular licensed registered nurses, appears to have a major, negative impact on the quality of patient care, either due to the increased reliance on untrained and relatively inexperienced staff, or due to overworked, trained staff. One physician who testified concluded that "We are seeing in hospitals that intelligent nurses are making dumb mistakes because they are overworked and stressed out.".

B. Need for Whistleblower Protections

Nurses and physicians testified that health care providers in hospitals often fear retaliation from their employers if criticisms or concerns are voiced about hospital working conditions or the quality of patient care; many of these witnesses attributed this fear to the growth of managed care. While retaliation can take various and sometimes subtle forms, the one commonly reported to the Committee involves being fired from current employment, with several witnesses telling the Committee they could be fired over the content of their testimony before the Committee. One witness relayed that, because she was told by superiors she would be fired if she provided specific detailed information to the Committee, she was instead providing general, "global" information. Virtually all who testified called for protections for those health care professionals who speak out critically on issues related to hospital working conditions and/or patient care, the so-called "whistleblowers". One witness who has reported on health care for several decades as a journalist wrote that:

> "Whistle blowers are virtually extinct; the very few who speak up are summarily dismissed. In my last few years as a newspaper reporter, phone calls from reliable, informed professionals about serious problems were rare indeed. We need to hear from nurse-advocates. They know, verse and chapter, the patient-care deficiencies that are now commonplace in hospitals, nursing homes and in the field of home health care."

Another witness relayed her personal experience with retaliation as a result of whistleblowing:

> "I am a Registered Nurse who has a personal interest in the Whistle Blowing Issue. Getting nowhere, after a year long paper battle with [a St. Louis-area hospital], I felt morally and ethically obligated to speak out on some potentially hazardous and unsafe patient care issues. This was not executed without a tremendous amount of soul searching as I had worked at this hospital as a loyal employee for 20 years. We chose to go public and refused anominity (sic). On June 1, 1998, we did a television story ..... Myself, a physician, and another Registered Nurse were interviewed. Five days later, June 6, 1999, my employment was terminated without negotiation."

One physician who described managed care systems as "suffocating" testified that the growth of managed care has decreased the ability of physicians to express their opinions. This witness believes that the quality of care suffers when medical professionals are intimidated by managed care systems. Based on written and oral testimony provided to the Committee, it appears that anxiety over the repercussions from whistleblowing are prevalent among those who provide health care. This anxiety was described as a significant impediment to the willingness of health care providers to serve as advocates for patients who are hospitalized. It is also apparent that many who provide health care do not feel there are any meaningful protections to insure that employers do not retaliate against employees who whistleblow.

The Missouri Hospital Association (MHA), which represents 152 hospitals in the state, provided information to the Committee outlining the existing protections for those reporting suspected health care quality violations. These include state protections through the Department of Health (DOH) hospital licensing regulations, which specify that a superior with the authority to hire and fire may not prohibit a hospital employee from discussing hospital operations with the DOH, or from disclosing information the employee reasonably believes is a violation of any applicable state or federal law or regulation. Whistleblowers may also file a complaint with the DOH which is required to investigate all such complaints. In addition, MHA outlined the whistleblowing protections available at the federal level, which include the expansion of the Civil False Claims Act to include prosecutions for the provision of unnecessary and/or substandard care. MHA officials testified that its board has adopted principles on whistleblowing, which include confidentiality protections and the assurance of prompt investigations. MHA also relayed to the

Committee that hospitals have made significant investments in corporate compliance programs designed to insure that employees know and comply with hospital regulations, including knowing how to report violations of applicable state and federal laws and regulations.

One witness with key involvement in her hospital's corporate compliance plan described her hospital's plan and the protections built in to safeguard against whistleblower retaliation. This hospital established a broad corporate compliance plan in 1977 to handle any legal or ethical concern which may arise. It is a requirement that employees of this hospital report any suspected problem; employees may remain anonymous and may report suspicions through a hotline or to any number of designated individuals. This corporate compliance plan has a no-retaliation clause for employees who in good faith report suspected problems.

Because the establishment of a hospital corporate compliance plan is strictly voluntary, data are unavailable on the number or percentage of hospitals in the state with such plans. It is therefore not known how many hospitals have internal mechanisms in place to offer protections for whistlebowing employees. However, if a case of whistleblowing retaliation is substantiated by the state Department of Health, the only sanction available to the DOH is hospital closure. DOH officials report there are no other sanctions authorized for the department to invoke in response to substantiated whistleblowing retaliation. The DOH has approximately 26 FTE devoted to all of their complaint investigations. While the Medicare program requires that complaints related to this program be investigated within 48 hours, other complaints are investigated anywhere from within several days to up to six months, depending upon the severity of the complaint and the

priority assigned by the DOH to the complaint.

C. Prevention of Needlestick Accidents and Injuries

Many witnesses testified that workplace safety issues are of concern, with the most commonly cited concern involving the risks to health care providers associated with accidental needle-sticks. The risks can be serious, since a number of infectious diseases, including fatal diseases such as Acquired Immune Deficiency Syndrome (AIDS), can be transmitted through contaminated needles. The Missouri Hospital Association reports that a substantial number of hospitals in the state have instituted some type of needle-stick injury/accident prevention training programs. Testimony was also provided to the Committee concerning the availability of new devices aimed at preventing accidental needle-sticks.

Providing new technology and implementing accident prevention programs are important ways to help reduce and minimize the incidence of needle-stick accidents and injuries. However, the Committee was provided with testimony suggesting that this issue is a complex one and not easily addressed through either the implementation of training programs alone or the use of safer devices because[4]:

1. The causes of needle-stick injuries vary from one facility to another, from one hospital facility to another, and from one profession to another profession. Therefore, there is no single prescriptive action that will likely remedy all of the accidental needle-sticks;

2. The causes of needle-stick injuries are often due to human error and not the result of using unsafe devices. Because health care workers are often over-worked and/or in a hurry,

accidents occur. Even with the use of new, safer devices, needle-stick injuries may not be reduced if the new, safer devices are perceived as too cumbersome or difficult to use, or as too complex to use efficiently;

3. The risks posed from accidental needle-sticks varies widely depending upon where and how a given device is used. Risks from "clean" needle-sticks (e.g., needles coming in contact only with sterile fluids) are insignificant as compared to the risks from a "dirty" needle-stick (e.g.,needles contaminated with blood or other body fluids). It is important to recognize that new devices, such as needle-less intravenous systems, may decrease a large number of clean needle-stick injuries, but may not affect the risks associated with needle-sticks involving contaminated needles;

4. New devices marketed as "safe" devices do not always work as intended to prevent needle-stick injuries because some needle-sticks occur before the new device is activated, some devices may increase the risks to the patients, or some devices are simply ill-conceived and impractical to use; and

5. Cultural issues can be significant impediments to using new devices, as medical staffs sometime cling to the traditional ways of "doing things" and may resist the adoption of new technologies.

D. Miscellaneous Issues related to the Quality of Care

During the four hearings, the Committee heard testimony dealing with several other issues related to the quality of patient care. One of these issues involves the changing demography of American society and among nurses. As the number of senior citizens continue to

grow, the demands on the health care system will also increase. Nurses are also aging, with the average age of licensed registered nurses reported to be approximately 44 years. There is a concern that the number of individuals entering nursing programs and seeking employment within hospitals will not keep pace with the ever-increasing need for quality health care, as nurses age and retire from the profession, and as fewer persons enter nursing programs because of the disincentives resulting from adverse working conditions within hospitals.

In addition to the safety concerns voiced about needle-stick injuries, the Committee heard testimony about workplace safety concerns involving latex glove allergies, back injuries from lifting or moving patients, and violence in the workplace. Related to this, a number of witnesses called for additional staff training to help make the work environment safer, and to help insure that quality health care is maintained.

Finally, the Committee heard from the Missouri Association of Nurse Anesthetists, which represents over 750 practicing advanced practice nurses. Of concern is the growing number of nurse anesthetists who work in solo practices primarily in rural areas; according to testimony, 70% of rural hospitals depend solely on Certified Registered Nurse Anesthetists (CRNA's) for anesthesia services. CRNA's are seeking prescriptive authority for brief, specified time periods immediately before and after surgery, to enable them to continue to meet the needs of primarily rural patients. This limited prescriptive authority would allow the administration of pain medications for patients who may not have direct or immediate access to an anaesthesiologist.

III. DISCUSSION AND RECOMMENDATIONS

Given the importance of insuring quality patient care in the increasingly complex organizational hospital environments in which much of the patient health care is delivered, the Committee plans to develop legislative proposals based on the following recommendations:

1. Nurse Staffing Levels

Some states have enacted minimum nurse-to-patient staffing ratios as a way to insure that quality patient care is provided by licensed, trained and experienced hospital staff. The Committee recognizes that the diversity of patient care needs found within hospitals, and the variations in care demands that can quickly develop and change from shift to shift and from ward to ward within a hospital setting must be taken into account when staffing levels are considered. The Committee recommends that all licensed acute care facilities establish staffing methodologies that provide for the appropriate mix of licensed and unlicensed staff based on the goal of insuring quality patient care. In addition, the Committee recommends that the Missouri Hospital Association and the Missouri Association of Nurses collaboratively develop minimum staffing level guidelines, connected to quality of care outcomes, and taking into account the staffing methodologies established by the facilities, and present these guidelines to the Department of Health and Missouri General Assembly in a written report no later than October 1, 2000. After a thorough review of these guidelines by the Missouri General Assembly and the DOH, it may be advisable (1) for the DOH to promulgate rules related to hospital licensure to require that all hospitals incorporate minimal staffing plans within their licensure documentation; or (2) for inclusion of minimal staffing levels for hospitals in state statutes.

2. Use of Untrained or Unlicensed Staff

The testimony relating to how serious the consequences can be for patients when untrained or unlicensed staff provide health care services was compelling. The Committee supports limiting hospital personnel to providing services in those areas for which they are trained or licensed, or both. Staff should also have clear and competent supervision from a physician, an experienced licensed registered nurse, or other appropriate superior. The Committee further supports appropriate oversight of staffing assignments within hospitals, to insure that the quality of care for patients is maintained, and to prevent the assignment of staff in those areas for which they do not possess a demonstrated competence. The Committee recommends that all hospitals include in their licensure documentation to the DOH their staffing assignment and staffing oversight plans, and their plans for remedial and ongoing staff training among all levels of personnel.

3. Whistleblower Protections

The Committee concludes that while existing state regulations and federal directives may offer some protections to health care whistleblowers, these are not easily used, are not generally known about, and their effectiveness often depends upon retaining costly legal advice. In addition, these existing protections are often ineffective because to enforce them requires the closure of entire hospitals. There is a need for less drastic sanctions which can be implemented without closing an entire hospital facility. There often is a significant delay between

the reporting of whistleblowing retaliation and an investigation, during which time whistleblowers may be out of work and without a steady income. The Committee therefore recommends that whistleblower protections be enacted into state statute, modeled after the language contained in House Committee Substitute for House Bill 129 & 108 (1999). The Committee further recommends that the DOH (1) seek additional staff for investigating health care-related complaints, in particular those complaints alleging whistleblower retaliation; and (2) propose to the Missouri General Assembly intermediate sanctions which can be effectively implemented to insure that hospitals are in compliance with both state regulations and statutory requirements. Such sanctions would apply to violations of state licensing regulations, including but not limited to whistleblower retaliation.

4. Prevention of Needlestick Injuries

New technologies can help health care professionals avoid accidental needle-sticks, but their use alone does not appear to offer a comprehensive solution. Increased staff training on needle-stick injury prevention can also help minimize the incidence of needle-stick injuries. The Committee recommends that the DOH (1) determine the number of hospitals with needle-stick injury prevention training programs in place; (2) make available suitable training programs to those hospitals without such training in place; (3) develop regulations requiring initial and ongoing safety training at all hospitals, with such training to include needle-stick injury prevention; and (4) assess and evaluate the varieties of technologies available to help minimize accidental needle-sticks, and report to the General Assembly on the reported effectiveness of these technologies.

1. These data derive from survey information provided by the Missouri Board of Nursing, which surveys nurses every two years on a variety of issues, including type of setting in which they are employed.

2. Christine Kovner, RN, PhD, and Peter J. Gergen, MPH, MD, "Nurse Staffing Levels and Adverse Events Following Surgery in U.S. Hospitals" (1998); U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research.

3. Carol Diemert, RN, BSN, MSN (Project Director), Concern for Care: Registered Nurses' Concerns about Practice in Acute Care Settings (1999); Minnesota Nurses Association.

4. The Committee credits Eddie Hedrick, Manager of the Infection Control Staff and Unit at the University of Missouri Hospitals and Clinics in Columbia with providing much of this information.